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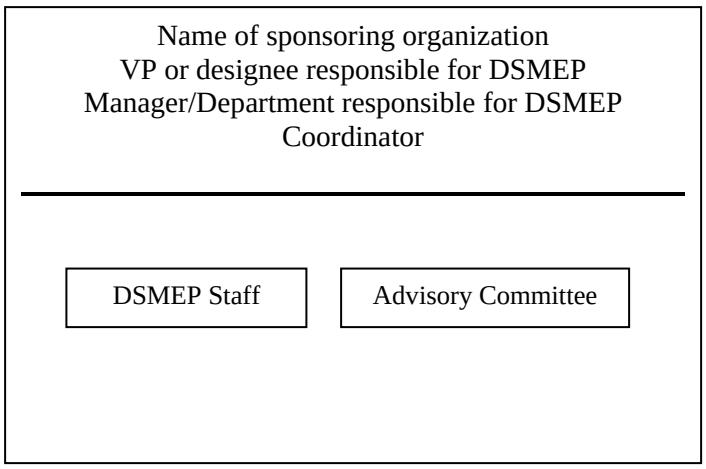
Standard 1: The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.

Review Criteria	Interpretive Guidelines
1.1 A signed mission statement encompassing the goals of the DSMEP is required. At certification and re-certification the mission statement should be signed by: ✓ The CEO or designee, **and** the Program Coordinator	Statement will be signed by CEO or designee every 3 years.
1.2 The program goals and/or objectives established for the DSMEP will be reviewed at least once annually.	Evidence of annual review by program coordinator.
1.3 A DSMEP organizational chart is required.	The organizational chart will include: ✓ Placement of the DSMEP within the organization ✓ Program staff ✓ DSMEP's advisory committee link **Sample Organizational Chart** 

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Standard 2: The DSME entity shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community and other stakeholders.

Review Criteria	Interpretive Guidelines
2.1 An established system (advisory committee, governing board, advisory body) comprising at least one each of the following professionals and diabetes advocates, identified by name and discipline, will be established and maintained: ✓ Physician ✓ Registered nurse ✓ Registered dietitian ✓ Behavioral science specialist ✓ Consumer ✓ Community representative ✓ If needed, individuals knowledgeable about special populations (e.g., migrants, adolescents, and others)	The behavioral science expert may be: ✓ Social worker ✓ Psychologist ✓ Psychiatric nurse specialist ✓ Chaplain ✓ Other professional with counseling credentials The consumer would preferably be a graduate of the DSMEP. The community representative can be any individual representing the service area. The consumer and community representative may be the same person, if not employed by the sponsoring organization.
2.2 The Annual Program Review process will: ✓ Review status of goals and/or objectives established for the DSMEP ✓ Analyze and review participants' access data and follow-up rates and other relevant data ✓ Review mission statement and appropriateness of DSMEP operations ✓ Review organizational structure to assess if the current structure is meeting the needs of the DSMEP operations and participants ✓ Analyze and review participant population data and how DSMEP is meeting the needs of the population it	The advisory committee minutes may be the means of documenting and communicating to MDCH the names of the committee attendees, dates of meeting and ongoing program activities, including subjects discussed, issues resolved, recommendations, approval policies and procedures, evidence of review, and other pertinent information.

is serving ✓ Review adequacy of resources, including personnel, budget, space equipment, curriculum, community resources ✓ Review effectiveness of DSMEP based on behavioral goals and other program outcome measure data ✓ Review and evaluate the continuous quality improvement (CQI) process (see Standard 10)	
2.3 The Annual Report, based on the findings of an annual program review, defines and guides the activities of the DSMEP for the next year and will include: ✓ Target audience ✓ Program objectives for the next year ✓ Participant access and follow-up mechanisms ✓ Instructional methods and resource requirements (including, personnel, budget, space, equipment/materials, curriculum, community resources) ✓ Outcome measure (s) chosen and means of measuring and evaluating the outcomes ✓ Community need	The statistical data reporting period is October 1 to September 30. Each DSMEP submits the Annual Report to DSMEP by a prearranged date
2.4 DSMEP will submit to MDCH annually: ✓ Statistical data as determined by MDCH by November 30 ✓ Annual Report, no later than January 30	

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Standard 3: The DSME entity will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.

Review Criteria	Interpretive Guidelines
3.1 Specific indicator of the target population(s) will include: ✓ Types of diabetes ✓ Age range ✓ Race and ethnicity ✓ Special needs, disabilities ✓ Language	The target population determination is facilitated by review and analysis of the following information: ✓ Prevalence of diabetes in the United States ✓ Prevalence of diabetes in Michigan ✓ Prevalence of diabetes in the organization's service area ✓ Demographic data related to race, ethnic backgrounds, gender, poverty level ✓ Community resources (such as financial stability, economic indicators such as unemployment rate, types of insurance reimbursement) ✓ Unique characteristics and special educational needs (e.g., learning disabilities, cognitive problems, hearing impairment, visual impairment, visual impairment, psychomotor problem, grade level, languages spoken or read, literacy rates, transportation systems, rates of uninsured or under-insured)
3.2 Specific indicators necessary to meet the self-management educational needs of the target population(s) will include: ✓ Personnel ✓ Budget ✓ Space ✓ Equipment/material ✓ Curriculum ✓ Community resources	**There should be evidence in writing that each of the indicators in 3.1 and 3.2 are addressed by the DSME entity annually.**

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Standard 4: A coordinator will be designated to oversee the planning, implementation, and evaluation of DSME. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.

Review Criteria	Interpretive Guidelines
4.1 The DSME entity has a designated coordinator.	Documents verifying the designated coordinator meets the requirements should be available for review and should include one or more of the following: resume, CV; job application; certificate of credential/s; college transcripts, continuing education certificates, and discipline specific license and/or registration.
4.2 The program coordinator is academically or experientially prepared in areas of chronic disease care, patient education and/or program management. Coordinator will meet <u>one</u> of the following requirements: ✓ Certified Diabetes Educator (CDE), <u>or</u> ✓ An average of 15 hours of DSME experience per month within the 12 months prior to assuming the coordinator role, <u>or</u> ✓ 15 hours of approved continuing education within one year prior to assuming the coordinator role or within three months of assuming the role.	There is a written job description of coordinator which includes: ✓ Academic preparation and/or experience in program management and in the care of person with chronic disease ✓ Recent didactic preparation in diabetes care or experience in DSME ✓ Oversight of program, including plan, implementation and evaluation of DSMEP ✓ Acting as liaison between program staff, the DSMEP advisory system and the agency administration.
4.3 The coordinator oversees the planning, implementation, and evaluation of the DSME.	The continuing education option should include a combination of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.

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Standard 5: DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a Certified Diabetes Educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.

Review Criteria	Interpretive Guidelines
5.1 The instructional team must consist of at least a registered dietitian and a registered nurse.	Documents verifying the instructor/s meet the requirements should be available to review and may include: discipline specific licenses and/or registrations, resume; CV; job application; certificates of credentials; college transcripts; and continuing education certificates.
5.2 Instructional staff will meet <u>one</u> of the following requirements:	
✓ Certified Diabetes Educator (CDE), <u>or</u>	Disciplines function within their own scope of practice.
✓ An average of 15 hours DSME experience per month within 3 months prior to assuming the instructor role, <u>or</u>	
✓ 15 hours of approved continuing education within one year prior to assuming the instructor role or within three months of assuming the instructor roll.	The continuing education option should include a combination of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills. Topics should be "diabetes-related, diabetes-specific, education or psychosocial and relevant" to DSME services.
✓ New instructional staff will have 15 hours of approved continuing education within 3 months of hire.	As needed, evidence of specialized training might include training certificates from pump manufacturers or documentation of pump-therapy training by experienced health care professional.

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Standard 6: A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME entity. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas (listed below) are to be provided.

Review Criteria	Interpretive Guidelines
6.1 There is a written curriculum, with learning objectives and criteria for specifying methods of delivery and evaluating successful learning outcomes, which is the framework for the DSME. The curriculum should include: ✓ Measurable learning objectives ✓ Detailed content outlines ✓ Instructional methods used ✓ A means of measuring if participants have achieved their learning objectives	"The education process is guided by a reference curriculum with learning objectives, methods of delivery and criteria for evaluating learning for the populations served (including pre-diabetes, diabetes type 1, type 2, GDM or pregnancy complicated by diabetes) in the following 9 content area: ✓ Describing the *diabetes disease process* and *treatment options* ✓ Incorporating *nutritional* management into lifestyle ✓ Incorporating *physical activity* into lifestyle ✓ Using *medication* safely and for maximum therapeutic effectiveness ✓ *Monitoring blood glucose* and other parameters and interpreting and using the results for self-management decision making ✓ Preventing, detecting, and treating *acute complications* ✓ Preventing detecting, and treating *chronic complications* ✓ Developing personalized strategies to address *psychosocial issues and concerns* ✓ Developing personalized strategies to prompt *health and behavior change (risk reduction)"*
6.2 There is a periodic review with revisions of the curriculum and/or course materials to reflect current evidence.	There is documentation of a review and necessary revisions of the curriculum and/or course materials by DSME instructor/s and/or advisory group at least annually.
6.3 The curriculum will include content on influenza and pneumococcal immunizations	Other adult immunizations may be included.

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Standard 7: An individual assessment and education plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.

Review Criteria	Interpretive Guidelines
7.1 An individualized, initial assessment, that includes face-to-face contact, will be completed with each participant before DSME begins and will relate to the nine content areas of the National Standards.	Face to face contact does not have to occur in a 1:1 setting, but is preferred. "Parts of the complete assessment may be deferred if applicable and the rationale for deferment documented."
7.2 The assessment will include information on participant: ✓ clinical information (diabetes and other pertinent clinical history) ✓ cognitive (diabetes self management knowledge and skills, functional health literacy) ✓ psychosocial and self care behaviors (readiness to learn, support systems, lifestyle practices, behavior change potential) ✓ Influenza and pneumococcal vaccinations.	A self-assessment or knowledge pre-test should not serve as the sole means of assessing and documenting the participant's knowledge, skill level and behaviors. If applicable, the assessment should include the participant's caretaker's ability to assist/assume diabetes management. For pump programs: document participant appropriateness for insulin pump therapy, and willingness to assume ongoing self-care and pump maintenance.
7.3 An individualized education plan with measurable learning objectives and at least one participant selected behavioral goal, based on the individualized assessment, will be collaboratively developed and implemented with each participant. The behavioral change goal will: ✓ be specific and measurable	There is evidence of an ongoing education planning and behavioral goal-setting based on the assessed and/or re-assessed needs of the participant.

✓ indicate how the goal will change behavior ✓ indicate how the changed behavior will help improve health and quality of life	
7.4 There is evaluation of the education plan after the educational intervention.	The DSME has a process for evaluating the education intervention to determine success of the education plan, including evaluation of behavioral goal progress and/or achievement.
7.5 The education process is documented in the permanent record.	Documentation includes other evidence of the education process: referral from provider, assessments, education plan, with dates of implementation/interventions, learning outcomes and plans for follow-up as indicated.
7.6 Participants will have a plan for post education self-management support for ongoing diabetes self care beyond the formal self management education process.	Reassessment by the diabetes educator, including a need to re-teach, or teach a support person, etc., will allow new achievable objectives to be developed for participants unable to meet the outlined educational objectives.
7.7 There will be an ongoing assessment of participant's progress to determine the attainment of the learning objectives and the need for revision of the education plan.	
7.8 Educators involved in patient care will demonstrate collaboration.	Example of collaboration include: ✓ A copy of the meal plan prepared with the participant ✓ Dietitian notes ✓ Social worker notes ✓ Nurse notes ✓ Staff meeting notes ✓ Letters to the referring physician, etc. DSME should take into account special educational needs such as vision impairment, mobility, mental state, functional status, financial resources. Characteristics more likely associated with elderly participants should be assessed and addressed as applicable (e.g., "polypharmacy," vision and hearing impairment, limited social support, decreased psychomotor skills, reduced ability to adapt and compensate for stressors and changes in memory storage and retrieval).

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Standard 8: A personalized follow-up plan for ongoing self management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self management support will be communicated to the referring provider.

Review Criteria	Interpretive Guidelines
8.1 Participants will have a plan for post education self-management support for ongoing diabetes self care beyond the formal self management education process.	There must be evidence of a personalized plan for follow-up that addresses Diabetes Self Management Support (DSMS). Examples include referral to worksite program, referral to support groups, referral to community programs, time frame for follow-up with physician, etc. There must be evidence that the DSMS follow-up plan was communication to the referring provider. Notation of when the participant should return for medical care to their primary care provider should be made.

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Standard 9: The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.

Review Criteria		Interpretive Guidelines
9.1	Attainment of goal/outcomes shall be measured regularly in order to evaluate the effectiveness of the educational intervention	A system for the collection and summary of participant behavior goals will be evident.
9.2	A summary of goals, using a systematic approach (e.g. AADE 7) will be included in the annual and statistical reports to MDCH.	There will be evidence that aggregate participant behavior goal data was used for program evaluation and planning.
9.3	At least one program outcome will be addressed annually.	There is evidence of a collection and summary of other program outcomes to evaluate DSME effectiveness. Examples include; patient satisfaction, provider satisfaction, A1C, BMI, weight loss, dilated eye exams, foot exams, etc.

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Standard 10: The DSME entity will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.

Review Criteria	Interpretive Guidelines
10.1 The DSME entity has a quality improvement process and plan in place for evaluating the education and program processes and program outcomes.	There is documentation of a CQI plan/process (e.g. written policy, annual program report, CQI meeting minutes).
10.2 Quality improvement projects are developed and implemented according to the plan.	There is documentation of at least one project following the quality improvement process and plan.
10.3 Results are used to make improvements in the DSME and will be integrated with the annual report.	There is evidence of application of the results of the quality improvement project to the DSME upon completion.

The above review criteria are based upon the 2007 National Standards* and the American Diabetes Association Review Criteria and Indicator Listing -7th Edition**. Both documents were used for reference and portions have been cited directly.

*Funnell, MM, Brown, TL, Childs, BP, et al. National Standards for Diabetes Self-Management Education. *Diabetes Care*, 30:1630-1637, 2007.

**http://professional.diabetes.org/Recognition.aspx?typ=15&cid=57999

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